

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

04151

Reg. Dist. No. 302

1. PLACE OF DEATH Washington		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Fred	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Capland HAGERSTOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR Brunswick	
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASH. CO. HOSPITAL Capland-Burkettville Rd		STREET ADDRESS (If rural, give location) 13 - 9th. Ave.	
3. NAME OF DECEASED (Type or Print) DARLENE MARIE AULT		4. DATE OF DEATH (Month) (Day) (Year) Apr. 22 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 2/22/32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, Landsdale Tube Factory		9. AGE last birthday 19 yrs.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Russell H. Ault		11. BIRTHPLACE (State or foreign country) Brunswick, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		14. MOTHER'S MAIDEN NAME Gussie V. Corder	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Russell H. Ault	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Antecedent cause(s) (b) Multiple fractured ribs Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) pneumo-hemothorax--shock		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY Route #512 Capland	(CITY OR TOWN) (COUNTY) (STATE) Wash. Md.
TIME (Month) (Day) (Year) (Hour) OF INJURY 4. 21 '51 11:30	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Auto overturned on road was passenger
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE S. Robert Wells M.D. DEPUTY MEDICAL EXAM.		DATE SIGNED Apr. 22 '51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4-24-51	NAME OF CEMETERY OR CREMATORY Park Heights Cemetery
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Apr. 22, 1951	24. FUNERAL DIRECTOR Andrew K. Coifman, Hagerstown, Md.	LOCATION (City, town, or county) (State) Brunswick, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct way is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

Evidence for addition
in 18 shwon On:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04152

FILED No. G 132 APR 13 1957 CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u> LENGTH OF STAY (in this place) <u>45 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u> STREET ADDRESS (If rural, give location) <u>W. Main Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Reed</u> (Middle) <u>Baker</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-27-75</u>
9. AGE last birthday <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Mrs. Celia Shockey (daughter)</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Pulmonary Hemorrhage</u>			
Antecedent cause(s) (b) <u>No previous evidence of lung disease (4/13/51 aka)</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Leukemia</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 2, 1957</u> to <u>April 2, 1957</u> , that I last saw the deceased alive on <u>April 2, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Anthony M. Hancock</u>		DATE SIGNED <u>4/4/57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4-5-57</u> NAME OF CEMETERY OR CREMATORY <u>Parkhead Evan Church Cem.</u> LOCATION (City, town, or county) (State) <u>Wash. Md.</u>	
DATE REC'D BY LOCAL REG. <u>4-5-57</u>		REGISTRAR'S SIGNATURE <u>Ch. R. Bast</u> ADDRESS <u>Hancock, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 6 1961
BUREAU V. B.

04153

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>341 N. Jonathan St.</u>		STREET ADDRESS <u>341 N. Jonathan St.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sharon</u> (Middle) <u>Elizabeth</u> (Last) <u>Beckett</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>8/26/1949</u>
9. AGE last birthday <u>1</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Ralph N. Beckett</u>	
14. MOTHER'S MAIDEN NAME <u>Lillian L. Jones</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT <u>Ralph N. Beckett 341 N. Jonathan St.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute meningococcus meningitis
(Waterhouse-Friderichsen)

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>None</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

S. Robert Wells M.D.

DEPUTY MEDICAL EXAM

ADDRESS 115 N. Potomac St.

DATE SIGNED

4/5/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4-5-51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Apr 5, 1951</u>	REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	24. FUNERAL DIRECTOR <u>William H. Downey</u>	ADDRESS <u>291 Friedrich St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and OR give nearest town) HAGERSTOWN TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN TOWN STREET ADDRESS (If rural, give location) 1001 CORBETT ST.	
3. NAME OF DECEASED (Type or Print) CHARLES (First) EBBERTT (Middle) BERRY (Last)		4. DATE OF DEATH (Month) APRIL (Day) 15 (Year) 1951	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED	8. DATE OF BIRTH 6/13/1891
9. AGE last birthday 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WOOD FINISHER	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WALTER H. BERRY		14. MOTHER'S MAIDEN NAME SARAH ADAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 214-09-6992	
17. INFORMANT AND ADDRESS MRS. LILLIAN BERRY		1001 CORBETT ST HAGERSTOWN MD	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Pulmonary Embolus**

Antecedent cause(s)

(b) **Adeno Carcinoma of Rectum**(c) **46d**

INTERVAL BETWEEN ONSET AND DEATH

5 hrs
9 mo +

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 4/6/51	19b. MAJOR FINDINGS OF OPERATION CARCINOMA of Rectum	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4/2**, 19**51**, to **4/15**, 19**51**, that I last saw the deceasedalive on **4/15**, 19**51**, and that death occurred at **640 A.** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/17/51	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) (State) Hagerstown, Md.
DATE REC'D BY LOCAL REG. Apr. 16, 1951	REGISTRAR'S SIGNATURE Charles H. Bowers	24. FUNERAL DIRECTOR W. J. Horne	ADDRESS Hagerstown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 1951

BUREAU V. S.
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **306**

04155

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Smithsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Smithsburg Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>VIRGIE</u>	(Middle) <u>E</u>	(Last) <u>Blickenstaff</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-28-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	9. AGE last birthday <u>63</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Daniel Walz</u>		14. MOTHER'S MAIDEN NAME <u>Clara Poffinger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Edw. Blickenstaff, Smithsburg, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Pyelonephritis

Antecedent cause(s)

(b) Rheumatoid Arthritis, Chronic, severe(c) giving rise to the above cause stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

1 year
years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1950, to 14 Apr, 1951, that I last saw the deceased alive on 14 Apr, 1951, and that death occurred at 7:24 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION (REMOVAL) (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 17-51Geo. W. FergusonCarl F. Bittl Myersville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16

RECEIVED
APR 18 1951
BUREAU V. S.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Wash	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown		LENGTH OF STAY (in this place) 26 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 216 N. Locust St				STREET ADDRESS 216 N. Locust St.			
3. NAME OF DECEASED (First) Certude		(Middle) A.		(Last) Boyd		4. DATE OF DEATH (Month) (Day) (Year) Apr. 11 1951	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Mar. 24 1905	9. AGE last birthday 46 yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Near Chewsville Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harvey C. Lantz				14. MOTHER'S MAIDEN NAME Emma Unger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. 214-09-1988		17. INFORMANT AND ADDRESS Mr. John W. Boyd Hag. Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) Carcinoma - Amp.							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION Nov. 1950		19b. MAJOR FINDINGS OF OPERATION Carcinoma - Pelvis -				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 29, 1950, to April 11, 1951, that I last saw the deceased alive on April 11, 1951, and that death occurred at 8:05 p.m., from the causes and on the date stated above.							
SIGNATURE Phil. H. Hestman		(Degree or title) MD		ADDRESS 1544 W. Locust St		DATE SIGNED 4/13/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Apr. 14, 1951		NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		LOCATION (City, town, or county) Hagerstown Md.	
DATE REC'D BY LOCAL REG. Apr. 13, 1951		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Scott F. Minnich & Son		ADDRESS Hag. Md.	

RECEIVED
APR 16 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04157
304

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u> LENGTH OF STAY (in this place) <u>74 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>East Main Street</u>		STREET ADDRESS (If rural, give location) <u>East Main Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary Frances Breakall</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 21 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-11-77</u>
9. AGE last birthday <u>74</u> yrs.		10. AGE last birthday (If under 1 year 1 year 24 hrs. Months Days Hours Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Easton</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Strouble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Mrs. Reba Courtney (daughter)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>Cerebral Hemorrhage</u> <u>Cirrhosis Liver</u> <u>Chronic Nephritis</u>	
Antecedent cause(s) (b) <u>592X</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>131a</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED (Specify) (City or town) (County) (State)	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Apr 18, 1957 to Apr 21, 1957, that I last saw the deceased alive on Apr 20, 1957, and that death occurred at 1030 A.M. from the causes and on the date stated above.

SIGNATURE J. M. Shaffer ADDRESS Md Hancock Md DATE SIGNED 4/23/57

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 4-24-57 NAME OF CEMETERY OR CREMATORY St. Peter's Catholic LOCATION (City, town, or county) (State) Hancock, Md.

24. FUNERAL DIRECTOR Charles R. Bast ADDRESS Hancock, Md.

DATE REC'D BY LOCAL REG. 4/23/57 REGISTRAR'S SIGNATURE J. A. Heller

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 25 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

04158

1. PLACE OF DEATH COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BOONSBORO		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS GUILFORD CONVALESCENT HOME		STREET ADDRESS (If rural, give location) 28 NORTH AVE.	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
NETTIE	LOUISE	BUCHANAN	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 5/6/1865
10a. USUAL OCCUPATION (Give kind of work done during most of year, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 85 yrs.
13. FATHER'S NAME WILLIAM H. ROHRER		14. MOTHER'S MAIDEN NAME MARY E. FUNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS MR. W.H. BUCHANAN HAGERSTOWN, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

(b)

*Arterio-sclerosis**10 years*

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *April 6*, 19*51*, to *April 10*, 19*51*, that I last saw the deceased alive on *April 10*, 19*51*, and that death occurred at *11:10 A.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>4/13/51</i>	<i>Rose Hill Cem.</i>	<i>Hagerstown Md</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>April 12, 1951</i>	<i>John H. Back</i>	<i>W. J. Herment</i>	<i>Hagerstown, Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

04159

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
TOWN <u>Cascade</u>		TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS <u>RFD #2</u>	
3. NAME OF DECEASED (Type or Print) <u>Michelle</u> (First) <u>Burton</u> (Middle) <u>Burton</u> (Last)		4. DATE OF DEATH <u>April 9</u> 1951 (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 24, 1886</u>
9. AGE last birthday <u>64</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>James Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Burton</u>		14. MOTHER'S MAIDEN NAME <u>Betsy Poole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>unk.</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

Some yrs.

Antecedent cause(s)

(b)

Arterio-sclerosis Heart Disease

some yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Hypertensive Cardio-vascular Disease

Some yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan. 5, 1951, to April 9, 1951, that I last saw the deceased alive on April 9, 1951, and that death occurred at 8:40 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Daniel Rai

M.D. Ritchie Hospital, Cascade, Md.

7/9/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 12, 1951</u>	<u>Calverville Md</u>	<u>Montgomery Co Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>7/9/51</u>	<u>J. L. A. Bowman</u>	<u>Robert A. Snodgrass</u>	<u>Frederick Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 12 1951

BUREAU V. S.

04160

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>651 Potomac Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LELA</u> <u>CAMPION</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>32</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 15, 1867</u>
9. AGE last birthday <u>84</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Cearfoss</u>		14. MOTHER'S MAIDEN NAME <u>Angeline Lutz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs James H. Harley</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 10, 1951, to April 24, 1951, that I last saw the deceasedalive on April 22, 1951, and that death occurred at 9 11 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 24, 1951Thomas H. BowersAndrew K. Coffman Hagerstown, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Boonsboro</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Boonsboro</u> STREET ADDRESS (If rural, give location) <u>S. Main St</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Kieffer</u> (Middle) <u>Chase</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>19</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 7, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Bus Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Buses</u>	9. AGE last birthday (If under 1 year, Months Days Hours Min.) <u>73-2-12</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>near Mississippi Ind. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henrich Chase</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Marker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None.</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Cora Chase Boonsboro Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary Occlusion

420.1 Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

92d

(b) Generalized Arteriosclerosis(c) Chronic Effusions in Thorax

INTERVAL BETWEEN ONSET AND DEATH

Sudden2 yrs. 3 mos2 weeks

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Nervousness - Severe depression of heart2 yrs. 3 mos

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1949, to April 19, 1951, that I last saw the deceased alive on April 19, 1951, and that death occurred at 8:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 22 1951Wm H. PowersWm F. Best & SonsBoonsboro Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

625516

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APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Miller

04162

Evidence for addition
in 4 shown on:

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

FILE No. G 132 APR 19 1951

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>2105 Virginia Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>GAIL</u>	<u>FRANCES</u>	<u>DRAWBAUGH</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>April</u>	<u>10</u>	<u>1951</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 12, 1895</u>
9. AGE last birthday	10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
<u>55 yrs.</u>	<u>Own Home</u>		<u>Chambersburg, Penna.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
		<u>Charles H. Patterson</u>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)	
<u>Anna M. Foust</u>		<u>No</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS	
<u>None</u>		<u>David G. Drawbaugh</u> <u>2105 Virginia Ave. Hagerstown, Md.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<u>Cerebral thrombosis of sigmoid - metastasis</u>		<u>12/1</u>
Immediate cause	(a) <u>To Liver</u>	
Antecedent cause(s)	(b) <u>(?)</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 4/2-1951 19b. MAJOR FINDINGS OF OPERATION <u>As in Q18</u>		
21. ACCIDENT SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<u>0</u>	<u>0</u>	<u>0</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>0</u>

22. I hereby certify that I attended the deceased from March 1, 1951, to April 10, 1951, that I last saw the deceased alive on 4/9-1951, and that death occurred at 8 2 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/12/51</u>	<u>Rest Haven Cemetery</u>	<u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr. 12, 1951</u>	<u>David G. Drawbaugh</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04163

Reg. Dist. No. 301

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Williamsport Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bethesda Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium</u>		STREET ADDRESS (If rural, give location) <u>5516 Huntington Parkway</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>May</u> (Middle) <u>Brockenbrough</u> (Last) <u>Evans</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 1 1868</u>
9. AGE last birthday <u>82</u> yrs.		10. If under 1 year: Months <u>10</u> Days <u>21</u> Hours <u>19</u> Mins. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Louisville Ky.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Brockenbrough</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Quarrier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Brockenbrough Evans Cranberry Lake N.Y.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Vascular hypertension with apoplexy

INTERVAL BETWEEN ONSET AND DEATH
5 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Chronic arthritis

19a. DATE OF OPERATION None 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

Attending physician out of town

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at 8:45 A.m., from the causes and on the date stated above.

SIGNATURE

(Deputy title)

DEPUTY MEDICAL EXAMINER 115 N. Potomac St.

DATE SIGNED

WASH. CO., MD.

Hagerstown, Md.

4/24/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF, April 28 1951

NAME OF CEMETERY OR CREMATORY Bradford Cemetery

LOCATION (City, town, or county) Bradford Vermont

(State)

DATE RECD BY LOCAL REG. April 23 51

REGISTRAR'S SIGNATURE E. Lee McElroy

24. FUNERAL DIRECTOR

Albert L. Leaf Williamsport Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 30 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04164

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Ohio</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Akron</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>956 Lanvale Street</u>		STREET ADDRESS (If rural, give location) <u>Not Known</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Howard J. Felix</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 10 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>1-12-1900</u>
9. AGE last birthday <u>51</u> yrs.		10. If under 1 year: Months Days Hours Mins. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Timber Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tucker Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John A. Felix</u>		14. MOTHER'S MAIDEN NAME <u>Isabel M. Krebs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>234-18-0523</u>	
17. INFORMANT AND ADDRESS <u>Clyde Trumpower, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of lung

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

19a. DATE OF OPERATION work

21. ACCIDENT (Specify) M SUICIDE HOMICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

INTERVAL BETWEEN ONSET AND DEATH

unknown

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from 3 Apr, 1951, to 10 Apr, 1951, that I last saw the deceasedalive on 10 Apr, 1951, and that death occurred at 1058 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City/ town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 12, 1951W. H. BowersC. M. Suter & Sons, Hagerstown, Md.10 Apr 51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

950306

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04165

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>		STREET ADDRESS (If rural, give location) <u>Main Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Rebecca Ellen Fletcher</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 9 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6-22-63</u>
9. AGE last birthday <u>87</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>James Norris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hunsucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Russel C. Fletcher (son)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic myocarditisAntecedent cause(s) Pulmonary failureDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last DemilitatedII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar 2, 51, to Apr 9, 51, that I last saw the deceasedalive on Apr 7, 51, and that death occurred at 3:30 A.M. from the causes and on the date stated above.SIGNATURE Wm Shaffer MD ADDRESS Hancock, Md. DATE SIGNED 4/10/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4-11-51</u>	<u>Piney Plains Meth.</u>	<u>Allegheny Co.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-11-51</u>	<u>G. H. Miller</u>	<u>Charles R. Bast</u>	<u>Hancock, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Security</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>R. F. D. #5</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edna</u> (Middle) <u>Pauline</u> (Last) <u>Gillespie</u>	4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-23-1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>50</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Union Bridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Emma Britner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>George B. Gillespie, Security</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lymphosarcoma

Antecedent cause(s) (b) 200.1

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 55e

INTERVAL BETWEEN ONSET AND DEATH
4 mo.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 6, 1951, to April 5, 1951, that I last saw the deceased alive on April 5, 1951, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 7, 1951

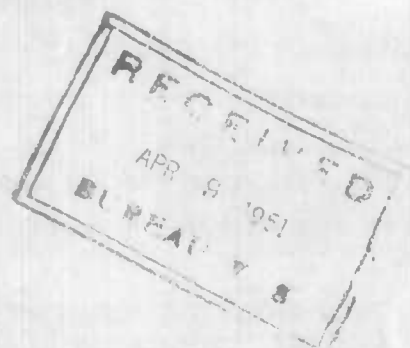
Chas. H. Gowers

C.M. Suter & Sons, Hagerstown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		
TOWN <u>Hagerstown</u>			TOWN <u>Williamsport</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. County Hospital</u>			STREET ADDRESS (If rural, give location) <u>203 South Artizan St.</u>		
3. NAME OF DECEASED (First) (Middle) (Last) <u>Lewis Franklin Gray</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 2 1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>12-28-1870</u>	9. AGE last birthday <u>80 yrs.</u>	10. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Business</u>		
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles M. Gray</u>			14. MOTHER'S MAIDEN NAME <u>Lidia A. Harrison</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY No. <u>220-16-3861</u>		
17. INFORMANT AND ADDRESS <u>John Gray, Williamsport, Md.</u>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arterio-sclerotic Heart Disease with myocardial failure

INTERVAL BETWEEN ONSET AND DEATH
10 yrs +

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work Not While At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 Feb, 1951, to 2 Apr, 1951, that I last saw the deceased

alive on 1 Apr, 1951, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 3, 1951

Chas. H. Howard

C.M. Puter & Sons, Hagerstown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

590656



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Robt Campbell

04168

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>720 Weldon Place</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>720 Weldon Place</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>HELEN ELIZABETH GRIFFITH</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 20 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 24 1908</u>
9. AGE last birthday <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawrence H. Francis</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Eicholtz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>315-07-7238</u>	
17. INFORMANT AND ADDRESS <u>Francis A. Griffith</u>		18. MEDICAL CERTIFICATION <u>720 Weldon Place Hagerstown Md.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Carcinoma of the Adrenal Gland</u> Antecedent cause(s) (b) <u>= Cushings Syndrome</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pyelonephritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>6 mos</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Nov 2, 1950</u> , to <u>April 20, 1951</u> , that I last saw the deceased alive on <u>April 14, 1951</u> , and that death occurred at <u>7:20 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert Vh Campbell MD</u>		ADDRESS <u>Hagerstown Md</u>	
DATE SIGNED <u>4/21/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/23/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG <u>Apr. 22, 1951</u>		REGISTRAR'S SIGNATURE <u>Shash Bowers</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 24 1951

BUREAU V. S.

CERTIFICATE OF DEATH

Dr wells

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u> LENGTH OF STAY <u>1 1/2</u> Hour (If this place)		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Negley Bldg W. Wash. St</u>		STREET ADDRESS (If rural, give location) <u>40 East Franklin St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>FREDERICK DORSEY GRUBER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 10 1951 19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 11 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, give nearest town) <u>Photographer - Self Employed</u>	
10b. KIND OF BUSINESS OR <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Martin M. Gruber</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Lavelly</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Albert S. Gruber</u>	

18. MEDICAL CERTIFICATION <u>416 Jefferson St Hagerstown Md</u>		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Acute coronary occlusion</u>		
Antecedent cause(s) (b) <u>420/1</u> <u>94a</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>None</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

S. Robert Wells M.D.

DEPUTY MEDICAL EXAMINER

WASH. CO., MD.115 N. Potomac Hagerstown, Md.

DATE SIGNED

4/11/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/13/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co. MD</u>
DATE REC'D BY LOCAL REG. <u>Apr 12/1951</u>	REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>

074849

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 16 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

04170

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Annapolis</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Seale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS <u>?</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>George Elbert Hardesty</u>		4. DATE OF DEATH <u>April 10 1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unfk.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63 yrs.</u>
13. FATHER'S NAME <u>James Hardesty</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unfk.</u>		16. SOCIAL SECURITY No. <u>unfk.</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <u>450.0</u>	(a) <u>Encephalomalacia due to arterio-sclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>some months</u>
Antecedent cause(s) <u>83c</u>	(b) <u>Generalized arterio-sclerosis</u>	<u>many yrs.</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 15, 1949, to April 10, 1951, that I last saw the deceasedalive on April 10, 1951, and that death occurred at 9:25 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/11/51</u>	<u>Woodfield Cemetery</u>	<u>Baltimore, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/10/51</u>	<u>John R. Loshman</u>	<u>T. G. Hardesty & Son</u>	<u>Seale, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 19 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04171

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest TOWN) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location) <u>22 Ruby Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIE</u> (Middle) <u>NONE</u> (Last) <u>HARRIS</u>	4. DATE OF DEATH	(Month) <u>April</u> (Day) <u>3</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4/1/1899</u>
9. AGE last birthday <u>52</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Private family</u>	11. BIRTHPLACE (State or foreign country) <u>Rocky Mount, N.C.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Servant</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>William Harris 22 Ruby Ave. Hagerstown, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Valvular Heart Disease with myocardial failure</u>			<u>unknown</u>
421.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>90d</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>W</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>31 March</u> , 19 <u>51</u> , to <u>3 Apr</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2 Apr</u> , 19 <u>51</u> , and that death occurred at <u>6:30 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J J Lusby MD</u> (Degree or title)		ADDRESS <u>2301 Potomac / Hagerstown Md</u> DATE SIGNED <u>4 Apr 51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/5/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr 5, 1951</u>	REGISTRAR'S SIGNATURE <u>Wm H. Dombrey</u>	24. FUNERAL DIRECTOR <u>William H. Dombrey</u>	ADDRESS <u>291 Fredrick St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

720826



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

04172

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benevola Rural</u> TOWN <u>Benevola</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Boonsboro R. 1</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benevola Rural</u> TOWN <u>Benevola</u> STREET ADDRESS (If rural, give location) <u>Boonsboro Md. R. 1</u>	
3. NAME OF DECEASED (Type or Print) <u>Fillie Catherine</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>April - 19 - 1951</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>January - 21 - 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>77 yrs - 2 mo - 18 ds</u> If under 1 year: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Headsville W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. W. Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Laura V. Gilbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>S. H. Hines Boonsboro Md. R. 1</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic myocarditis</u> Antecedent cause(s) (b) <u>Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Varicose veins (Legs)</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 9, 1951, to April 19, 1951, that I last saw the deceased alive on April 18, 1951, and that death occurred at 4:20 a.m., from the causes and on the date stated above.

SIGNATURE John H. Bart (Degree or title) M.D. ADDRESS Boonsboro Md. DATE SIGNED 4/20/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 21, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Benevola Cemetery</u>	LOCATION (City, town, or county) <u>Benevola Wash. Co. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>April 21, 1951</u>	REGISTRAR'S SIGNATURE <u>John H. Bart</u>	24. FUNERAL DIRECTOR <u>W. J. Bart & Sons</u>	ADDRESS <u>Boonsboro Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04174

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown R.#1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hospital		STREET ADDRESS (If rural, give location) Cavetown, Pike	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
Sarah	Jane	Hoover	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH April 3/51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10h. KIND OF BUSINESS OR INDUSTRY ----	9. AGE last birthday If under 1 year: Months 1 Days 17 If under 24 hrs: Hours 17 Min.
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Ned Hoover		14. MOTHER'S MAIDEN NAME Sarah Jane Plummer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Ned Hoover Hagerstown? Md. Route #1			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Bilateral Congenital Hare lip c		17 hrs.
Antecedent cause(s) (b) Tracheal Anomaly		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19h. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4/3**, 19**51**, to **4/4**, 19**51**, that I last saw the deceased alive on **4/3**, 19**51**, and that death occurred at **3:25 A.** m., from the causes and on the date stated above.

SIGNATURE **Ernest F. Poole M.D. Physician Hagerstown, Md** ADDRESS **Hagerstown, Md.** DATE SIGNED **4/4/51**

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **4/5/51** NAME OF CEMETERY OR CREMATORY **Rose Hill Cemetery** LOCATION (City, town, or county) **Hagerstown Md.**

DATE REC'D BY LOCAL REG. **Apr 5, 1951** REGISTRAR'S SIGNATURE **Chas. H. Flowers** 24. FUNERAL DIRECTOR **Andrew K. Coffman** ADDRESS **Hagerstown, Md.**

20 4031990990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>WASHINGTON</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAVERSTOWN</u> TOWN <u>HAVERSTOWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>123 W. Franklins St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS <u>548 Salem Ave.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Anna</u> (Middle) <u>Mae</u> (Last) <u>Hosfeld</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4/2/1909</u>
9. AGE last birthday <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silk weaver</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Colbert</u>		14. MOTHER'S MAIDEN NAME <u>Ella Griner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-4482</u>	
17. INFORMANT <u>Mrs. Pearl Miller, Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Acute cerebral hemorrhage</u>		
(b) Antecedent cause(s) <u>to reported late (5/16/51 akc)</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>blood chemistry</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	<u>No barbiturate, arsenic or mercury present in blood.</u>
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19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>S. Robert Miller, M.D.</u>	(Degree or title) <u>DEPUTY MEDICAL EXAMINER</u>	ADDRESS <u>115 N. Patomac Hagerstown, Md.</u>	DATE SIGNED <u>4/18/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>4/19/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 19, 1951</u>	REGISTRAR'S SIGNATURE <u>L. H. Bowers</u>	24. FUNERAL DIRECTOR <u>W. T. Norment</u>	ADDRESS <u>Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
TOWN <u>Bethesda</u>		TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Paul St.</u>		STREET ADDRESS (If rural, give location) <u>St. Paul St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>James</u> <u>Huffer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April - 1 - 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>October 30, 1865</u>
9. AGE last birthday (If under 1 year Months Days Hours) <u>85-5-1</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Shakabong Wash. Co. Md.</u>	
13. FATHER'S NAME <u>Michael Bender</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bromley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No. <u>None.</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Joseph E. Beeler Sr. Bethesda Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocarditis(c) Cerebral Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

General debility

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 18, 1930, to April 1, 1951, that I last saw the deceasedalive on March 25, 1951, and that death occurred at 10:25 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

04176

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cascade</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		STREET ADDRESS (If rural, give location) <u>934 E. Preston St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Anna</u> (Middle) <u>Scott</u> (Last) <u>Hunter</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept. 29, 1860</u>
9. AGE last birthday <u>90</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind. Casualty Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Barry Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Mary McCollem</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY No. <u>unk.</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Hypertensive Cardio-Vascular Disease</u>	<u>many yrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arterio-sclerosis, generalized</u>	<u>many yrs.</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		?
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Glaucoma, ou.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb. 23, 1957, to April 1, 1957, that I last saw the deceased alive on April 1, 1957, and that death occurred at 11:40 P.m., from the causes and on the date stated above.

SIGNATURE Daniel Rai, M.D. ADDRESS Ritchie Hospital, Cascade, Md. DATE SIGNED 4/1/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/4/57</u>	<u>Balto.</u>	<u>Balto. Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/3/57</u>	<u>A W Hedges</u>	<u>Wm Cook Inc.</u>	<u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

390736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

04177

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cascade</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>1 1/2 months</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> STREET ADDRESS (If rural, give location) <u>934 E. Preston St.</u>	
3. NAME OF DECEASED (First) <u>Martha</u> (Middle) <u>Lane</u> (Last) <u>Hunter</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>1951</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan. 29, 1863</u>	9. AGE last birthday <u>88</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Alexander Barry Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Mary McCollem</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>unk.</u>	17. INFORMANT AND ADDRESS <u>Hospital Record.</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Arterio-sclerotic Heart Disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Some years</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-vascular Disease</u>	<u>days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Glaucoma, ou.</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Glaucoma, ou.</u>		15 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1951, to April 12, 1951, that I last saw the deceased alive on April 12, 1951, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE Daniel Lai (Degree or title) M.D. ADDRESS Ritchie Hospital, Cascade, Md. DATE SIGNED 4/14/51

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/16/51</u>	<u>Balto</u>	<u>Balto. Md.</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/13/51</u>	<u>Wm. Beduch</u>	<u>Wm. Cook Inc.</u>	<u>1217 St. Paul St.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04178

Reg. Dist. No. 304

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hancock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hancock</u>	
TOWN <u>Rural - Hancock</u>		TOWN <u>Rural - Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #2</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. #2</u>	
3. NAME OF DECEASED (First) <u>Mary</u> (Middle) <u>Elizabeth</u> (Last) <u>Johnson</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>14</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10-26-02</u>
9. AGE last birthday <u>48</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lee Weller</u>		14. MOTHER'S MAIDEN NAME <u>Hester Yunker</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Frances Weller (daughter)</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>422.1 Antecedent cause(s) 93d</u>	(a) <u>Arterio sclerotic myocardial heart disease</u>	
(b) <u>Chr. myocardial heart failure grade IV</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION <u>NO</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
----------------------------------	----------------------------------	--

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE S. Robert Wells, M.D. (Degree or title) DEPUTY MEDICAL EXAM. Hagerstown, Md. DATE SIGNED April 16 '51

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF 4-17-51 NAME OF CEMETERY OR CREMATORY Stonebridge Brethren LOCATION (City, town, or county) Washington Co. (State) Md.

DATE REC'D BY LOCAL REG. 4-17/51 REGISTRAR'S SIGNATURE J. H. Miller 24. FUNERAL DIRECTOR Charles R. Bast ADDRESS Hancock, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 18 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Rohrersville OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) Rohrersville OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) David (Middle) Daniel (Last) Keedy		4. DATE OF DEATH (Month) April (Day) 21 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 20, 1856
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self	9. AGE last birthday 94 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Keedysville		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Keedy		14. MOTHER'S MAIDEN NAME Lucinda Breckbill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None	
17. INFORMANT Mrs. Ernest Young			

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Senility		2 mos. 9 days
Antecedent cause(s) (b) Arteriosclerosis		11
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis		4
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Feb. 12 , 19 51 , to April 21 , 19 51 , that I last saw the deceased alive on March 1 , 19 51 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above.		
SIGNATURE J. H. H. H. H. (Degree or title)		ADDRESS Mr. D. DATE SIGNED Boaschens. Ind.
23. BURIAL, CREMATION REMOVAL Burial	DATE THEREOF April 24, 1951	NAME OF CEMETERY OR CREMATORY Fair-View LOCATION (City, town, or county) Keedysville--Md (State)
DATE REC'D BY LOCAL REG. April 23/51	REGISTRAR'S SIGNATURE Wm. J. H. H. H.	24. FUNERAL DIRECTOR R. I. Earnshaw--Keedysville, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04180

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown Md. 6</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Middleburg Pike</u>	
3. NAME OF DECEASED (Type or Print) <u>Susan Sophie Rice</u> (First) <u>Keedy</u> (Middle) (Last)		4. DATE OF DEATH <u>April 3</u> (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 5 - 1884</u>
9. AGE last birthday <u>66</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Willard Rice</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Soches</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Keedy, J. Hagerstown Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic heart disease(c) Arteriosclerosis & hypertension

INTERVAL BETWEEN ONSET AND DEATH

2 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from July, 1950, to 2/10/51, 1951, that I last saw the deceasedalive on 3 April, 1951, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 5, 1951Charles HowardRest Haven Funeral Chapel Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Keadle

04181

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>511 Maryland Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>511 Maryland Ave.</u>	
3. NAME OF DECEASED (First) <u>MAUDE</u> (Middle) <u>ELIZABETH</u> (Last) <u>KENDALL</u>		4. DATE OF DEATH <u>Apr. 13, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Jan. 25, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>George Itnyre</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Jennie Williams</u>		14. INFORMANT AND ADDRESS <u>Mrs Nellie F. Cooper, Hagerstown, Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No. <u>None</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Occlusion (Thrombosis)

INTERVAL BETWEEN ONSET AND DEATH

10 minutes

Antecedent cause(s)

(b)

Hypertensionindef.

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Diabetes mellitus5 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Peripheral vascular disease undiagnosed

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-16, 1949, to 4-13, 1951, that I last saw the deceasedalive on Sept, 1950, and that death occurred at 11: A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Robert F. KeadleM.D.ROBERT F. KEADLE132 W. WASHINGTON ST.

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 16, 1951Robert F. KeadleAndrew K. CoffmanHagerstown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 18 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04182
Dr Bell

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1312 Oak Hill Ave</u>		STREET ADDRESS (If rural, give location) <u>1312 Oak Hill Ave</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MAXIMILIAN</u> <u>KIESEWETTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 8 1951</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 9 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager Antietam Paper Co</u>	
11. BIRTHPLACE (State or foreign country) <u>New York New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>214-09-1630</u>	
17. INFORMANT AND ADDRESS <u>Mrs Irma Kieseewetter</u>		18. MEDICAL CERTIFICATION <u>1312 Oak Hill Ave Hagerstown Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Myocardial failure due to

INTERVAL BETWEEN ONSET AND DEATH

About 15

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause lastArteriosclerotic heart disease.months.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JAN. 5, 1950, to APRIL 8, 1951, that I last saw the deceasedalive on APRIL 8, 1951, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

R. A. BreeM.D.Hagerstown, Md.April 10, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/10/51</u>	<u>Rest Haven cemetery</u>	<u>Hagerstown Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr. 10, 1951</u>	<u>Phyllis Hoovers</u>	<u>Andrew K. Coffman</u>	<u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290458

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
TOWN <u>HAGERSTOWN</u>		TOWN <u>HAGERSTOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WASHINGTON COUNTY HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>13 BURGER AVE.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOHN</u> (First) <u>HENRY</u> (Middle) <u>KINDLE</u> (Last)		4. DATE OF DEATH (Month) <u>APRIL</u> (Day) <u>23</u> (Year) <u>1951</u>	
6. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, OR FORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12/24/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACT PAINTING</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SIMON KINDLE</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE SMITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>220-05-6227</u>	
17. INFORMANT AND ADDRESS <u>MRS. MARIE KINDLE</u>		<u>HAGERSTOWN, MD</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Uremia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Unresolved pneumonia(c) Cancer of mediastinum with metastasis

INTERVAL BETWEEN ONSET AND DEATH

3 days6 months6 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/6....., 1951, to 4/23....., 1951, that I last saw the deceasedalive on 4/23....., 1951, and that death occurred at 12:40 p. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. George Jennings
136 Washington St. 12 $\frac{40}{\text{Feb.}}$

BUREAU V. S.

APR 26 1951

RECEIVED

04184

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>54 S. Potomac St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Wash.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>122 N. Locust St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Hiram</u> (First) <u>Kretzer</u> (Middle) <u>Kretzer</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>51</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5/25/65</u>
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Kretzer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Doyle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Non-vet.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-3433</u>	
17. INFORMANT <u>Mrs. Mabel Moore</u>		18. MEDICAL CERTIFICATION <u>122 N. Locust St.</u> <u>Hagerstown, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Gunshotwound through skull (suicide)

Antecedent cause(s) (b) Disorders or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY?
 Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? ☐ **PLACE (Home, farm, factory, street, office bldg., etc.)** Masonic Temple **(CITY OR TOWN)** Hagerstown **(COUNTY)** Wash. **(STATE)** Md.

TIME (Month) (Day) (Year) (Hour) Apr. 10 1951 1 A **INJURY OCCURRED** While at work **HOW DID INJURY OCCUR?** Shot self with .32 calibre revolver

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐

SIGNATURE S. R. Roberts + Wells, M.D. **(Degree or title)** DEPUTY MEDICAL EXAMINER **ADDRESS** 115 N. Potomac St. **DATE SIGNED** 4/11/51
WASH. CO., MD. Hagerstown, Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial **DATE THEREOF** 4/12/51 **NAME OF CEMETERY OR CREMATORY** Rose Hill Cemetery **LOCATION (City, town, or county)** Hagerstown, Md. **(State)**

DATE REC'D BY LOCAL REG. Apr. 11, 1951 **REGISTRAR'S SIGNATURE** Beauchamp **24. FUNERAL DIRECTOR** W. J. Norment **ADDRESS** Hagerstown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

510246

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Dr Miller

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04185

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> OR TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>303 East Wilson Blvd</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> OR TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>303 East Wilson Blvd</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELLIOTT</u> <u>C</u> <u>LONG</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Apr 7 1951</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 2 1875</u> <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman City Equipment Building</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Downsville Wash. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>David Long</u>		14. MOTHER'S MAIDEN NAME <u>Susan Royer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>314-09-6441</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna Mary Long</u>		18. MEDICAL CERTIFICATION <u>303 East Wilson Blvd</u> <u>Hagerstown Md</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <u>Cardio-Vascular Disease</u> Antecedent cause(s) (b) <u>Coronary Thrombosis?</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Sudden Death</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5-6 years</u> <u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>0</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>0</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1951</u> , to <u>April 7, 1951</u> , that I last saw the deceased alive on <u>4/7, 1951</u> , and that death occurred at <u>11</u> <u>P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Victor D. Miller</u>		DR. VICTOR D. MILLER, ADDRESS <u>131 W. WASHINGTON ST., HAGERSTOWN, MD.</u> DATE SIGNED <u>4/9-1951</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/10/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
DATE REC'D BY LOCAL REG. <u>Apr 10, 1951</u>		REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

763936

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04186

CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (in this place) <u>10 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>805 Maryland Ave.</u>		STREET ADDRESS (If rural, give location) <u>805 Maryland Ave.</u>	
3. NAME OF DECEASED (First) <u>Susan</u> (Middle) <u>Virginia</u> (Last) <u>Lawson</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>6</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 12-1868</u>
9. AGE last birthday <u>83</u> yrs.		10. AGE last birthday If under 1 year Moths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. Co md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ross</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Eikelberger</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary occlusion

Antecedent cause(s)

(b)

Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

24 hours10 years

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I hereby certify that I attended the deceased from April 2, 1951, to April 6, 1951, that I last saw the deceasedalive on April 5, 1951, and that death occurred at 12:15 P. am., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 9, 1951Phyllis LawsonAndrew K CoffmanHagerstown Md.Hagerstown Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
APR 11 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

04187

1. PLACE OF DEATH - COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md.</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg</u>	
TOWN <u>Leitersburg</u>		TOWN <u>Leitersburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Leitersburg Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>John Jacob Lowman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 6 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Aug. 10 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arick Co.</u>	9. AGE last birthday <u>78</u> yrs.
11. FATHER'S NAME <u>George U. Lowman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Annie Pickett</u>	
15. SOCIAL SECURITY No. <u>173-03-1631</u>		17. INFORMANT <u>Mrs. Clair Thompson, Leitersburg Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Cerebral hemorrhage

4/20.0

Antecedent cause(s)

(b) Arteriosclerotic heart disease

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT

(Specify)

SUICIDE
HOMICIDEPLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1944, to April 6, 1951, that I last saw the deceasedalive on April 5, 1951, and that death occurred at 2 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter J. Wolfinger M.D.132 South Broad StWaynesboro Penna 4-7-51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial4/9/51LeitersburgLeitersburg Washington Md.

DATE REC'D BY LOCAL REC.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

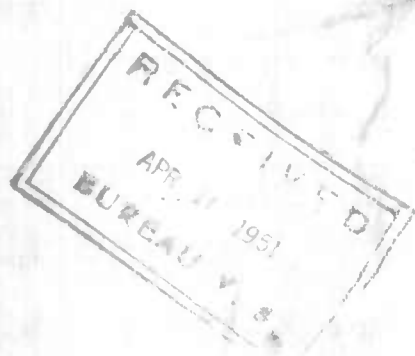
ADDRESS

April 8-51Geo. W. FergusonWalter J. Grove, Waynesboro Pa

692337

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 3.0.5

1. PLACE OF DEATH - COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Rural-Boonsboro		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Boonsboro R. F. D. #1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Lester		(First) David		(Last) Maphis	
4. SEX Male		5. COLOR OR RACE White		6. DATE OF DEATH April 25 1951	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widowed		8. DATE OF BIRTH June 26, 1903		9. AGE last birthday 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Winchester, Va	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME William Maphis		14. MOTHER'S MAIDEN NAME Virginia Ridenour	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None		17. INFORMANT AND ADDRESS Mrs. Vesta B. Maphis	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Hemorrhage (Gastric ulcer)					
Antecedent cause(s) (b) 540.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
(c)					
2. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
SIGNATURE D. W. Sittig		(Degree or title) Chief Coroner		ADDRESS Hagerstown Md DATE SIGNED 4/25/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 4-28-51		NAME OF CEMETERY OR CREMATORY Butler's Chapel	
LOCATION (City, town, or county) (State) Near Martinsburg, W. Va		24. FUNERAL DIRECTOR ADDRESS R. I. Earnshaw-Keedysville, Md			
DATE REC'D BY LOCAL REG April 27, 1951		REGISTRAR'S SIGNATURE John H. Bad			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 30 1951
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		CITY (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
TOWN HAGERSTOWN		TOWN HAGERSTOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSP.		STREET ADDRESS (If rural, give location) HAGERSTOWN RT. #6	
3. NAME OF DECEASED (Type or Print)	(First) LAUREN	(Middle) RAY	(Last) MARTIN
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH 1/8/51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 3 yrs. 3 mos. 11 days
13. FATHER'S NAME HENRY I. MARTIN		14. MOTHER'S MAIDEN NAME IVA ESHLEMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY No. NONE	17. INFORMANT AND ADDRESS MR. HENRY I. MARTIN HAGERSTOWN
		RE-#6 MD.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

571.0 Immediate cause (a) **acidosis**
 119a Antecedent cause(s) (b) **Gastroenteritis acute**
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

12 hrs

24 hrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 4/19, 1951 , to 4/19, 1951 , that I last saw the deceased alive on 4/19, 1951 , and that death occurred at 2:25 P. m. , from the causes and on the date stated above.		
SIGNATURE Dr. Bowman (Degree or title)		ADDRESS Hagerstown, Md DATE SIGNED 4/20/51
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
Burial	4/22/51	Paradise Church Cem.
LOCATION (City, town, or county) (State)	Washington County, Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
Apr. 20, 1951	Edward J. Zovers	W. J. Normant
		ADDRESS Hagerstown, Md

191081242407



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Maugensville</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Henry</u>	(Middle) <u>C.</u>	(Last) <u>Mauck</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>19</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 11, 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>barber</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John F. Mauck</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rosebraugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>214-03-7325</u>	
17. INFORMANT AND ADDRESS <u>Anna G. Mauck</u>		<u>Maugensville, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 481x
Antecedent cause(s) 33x
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) acute nephritis fatal

(c) Injuries

INTERVAL BETWEEN ONSET AND DEATH

4 hrs

10 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/9/51, 19....., to 4/12/51, 19....., that I last saw the deceased alive on 4/19/51, 19....., and that death occurred at 2:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 21, 1951

Pharrell Bowers

Fred W. Kraiss

Hagerstown, Md.

740849

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 23 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 N. Potomac St.</u>		STREET ADDRESS (If rural, give location) <u>210 N. Potomac St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Relmon</u> (Middle) <u>Frederick</u> (Last) <u>Miller</u>		4. DATE OF DEATH (Month) <u>Apr.</u> (Day) <u>5</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 2, 1869</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Near Reid Md.</u>	11. CITIZEN OF WHAT COUNTRY <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Filling Station Att.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline</u>	
13. FATHER'S NAME <u>Levi Miller</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C.L. Garver</u>		<u>Hag. Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Exacerbate Heart DiseaseAntecedent cause(s) (b) Arteriosclerosis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1949, to April 5, 1951, that I last saw the deceasedalive on April 5, 1951, and that death occurred at 8:10 p. m., from the causes and on the date stated above.SIGNATURE Wm. J. Miller (Degree or title) MD ADDRESS Hagerstown Md. DATE SIGNED 4/6/51

23. BURIAL / CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr. 8, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Luthern Cemetery</u>	LOCATION (City, town, or county) <u>Smithsburg Md.</u>	(State)
DATE REC'D BY LOCAL REG <u>Apr 7, 1951</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Miller</u>	24. FUNERAL DIRECTOR ADDRESS <u>Scott F. Minnich & Son Hag. Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

621668



RECEIVED
JUN 18 1964
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 307

04192

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wexford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wexford</u>	
TOWN <u>Wexford</u>		TOWN <u>Wexford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural Knoxville</u>		STREET ADDRESS (If rural, give location) <u>Rural Knoxville Md.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>Franklin</u> (Last) <u>Moss</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>2-3-1885</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year: Months <u>4</u> Days <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Latner Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. R.P.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Moss</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Holmes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>705-07-7725</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Annie Catharine Munday Knoxville Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

1 day

Antecedent cause(s)

(b) Chronic Hypertensive Nephritis??

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/21, 1951, to 4/26, 1951, that I last saw the deceasedalive on 4/26, 1951, and that death occurred at 2:35 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 27/51Mrs. Katherine DegenhartC. A. Zetser & Co. Brunswick Md.

970506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cascade</u> TOWN <u>Cascade</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pitkin Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Germanatown</u> TOWN <u>Germanatown</u> STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Foster</u> (First) <u>Thomas</u> (Middle) <u>Oden</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>11</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec 25, 1888</u>
9. AGE last birthday <u>65</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus driver</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Thomas Oden</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Reeves</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Hospital Records</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Carcinoma of rectum & metastases

INTERVAL BETWEEN ONSET AND DEATH
one year

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

6/6/50

Carcinoma of rectum & metastases to liver

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)

SUICIDE

HOMICIDE

INJURY

TIME (Month) (Day) (Year) (Hour)

OF INJURY

INJURY OCCURRED

While at

Work

Not While

At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 15, 1957, to April 11, 1957, that I last saw the deceased

alive on April 10, 1957, and that death occurred at 7:40 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

Buried

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

4/14/57

Greenwood

Washington DC

Washington DC

DC

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/12/57

John P. Buchanan

W. W. Chambers Co.

3072-N. St. Ave.

4/12/57

Dep. Asst. Registrar

W. W. Chambers Co.

3072-N. St. Ave.

4/12/57

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4/12/57

Dep. Asst. Registrar

W. W. Chambers Co.

3072-N. St. Ave.

4/12/57

Dep. Asst. Registrar

W. W. Chambers Co.

3072-N. St. Ave.

RECEIVED

APR 17 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore Dr. Wm Layman

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04194

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>723 No. Locust St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS (If rural, give location) <u>723 No. Locust St.</u>	
3. NAME OF DECEASED (Type or Print) <u>WILBUR PRESLEY POPE</u>	4. DATE OF DEATH <u>April 1 1951</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 13 1912</u>	9. AGE last birthday <u>38</u> yrs.	10. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pattern Maker</u>	12. KIND OF BUSINESS OR INDUSTRY <u>Fairchild</u>	13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	14. FATHER'S NAME <u>Randolph Pope</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>214-09-1398</u>	17. INFORMANT AND ADDRESS <u>William E. Ridgley</u>	18. MEDICAL CERTIFICATION <u>723 No Locust st</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Not definitely determined - presumed to be massive hemorrhage from intestinal tract (on basis of previous known occurrence Oct 11, 1950)</u> Antecedent cause(s) (b) <u>None</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>None</u>			<u>Questionable probably 5-6 hours</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April 1, 1951</u> , to <u>April 1, 1951</u> , that I last saw the deceased alive on <u>March 30, 1951</u> , and that death occurred at <u>8:50 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. D. Layman, M.D.</u>		ADDRESS <u>5 Public Square Hagerstown, Md</u>	DATE SIGNED <u>April 2, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/3/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr 3, 1951</u>	REGISTRAR'S SIGNATURE <u>Charles H. Powers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

570VVV

RECEIVED
APR 5 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04195

Reg. Dist. No. 303

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md. COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Clear Spring		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Clear Spring, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fairview Road		STREET ADDRESS Fairview Road	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) John (Middle) Allen (Last) Repp		(Month) April (Day) 17 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 3, 1875
9. AGE last birthday 76 yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David Repp		14. MOTHER'S MAIDEN NAME Susan Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) No		16. SOCIAL SECURITY No. 219-20-2859	
17. INFORMANT AND ADDRESS Mrs. Errol Miller- Clear Spring, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Carcinoma of the Stomach				Unknown	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Old Tuberculosis, pulmonary, healed Secondary anemia, severe		unknown unknown	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12-29-50, 19, to 4-17-51, 19, that I last saw the deceased alive on 3-12-51, 19, and that death occurred at 8:00 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Arlin Robert Cohen MD

Clear Spring, Maryland

4-19-51

23. BURIAL, CREMATION
REMOVAL, (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

April 20, 1951

Blairs Valley Cem.

Clear Spring Md.

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 20-51

J. W. Munday

Arlin R. Cohen Clear Spring Md.

820105

RECEIVED

MAY 7 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

04196
 Dr wells

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u> LENGTH OF STAY (If this place) <u>15 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>424 West Franklin St</u>		STREET ADDRESS (If rural, give location) <u>424 West Franklin St</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>JESSE CLAY RHODES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 9 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widower</u>	8. DATE OF BIRTH <u>Jan 27 1873</u>
9. AGE last birthday <u>78</u> yrs.		10. If under 1 year Moonths Days Hours Mto. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Foreman Retired Hagerstown Street Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Street Dept</u>	
11. BIRTHPLACE (State or foreign country) <u>Big Springs Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob D. Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>220-30-9708</u>	
17. INFORMANT AND ADDRESS <u>Ralph B. Rhodes</u>		18. MEDICAL CERTIFICATION <u>Big Springs Md</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Hypertensive arteriosclerotic</u>			
Antecedent cause(s) (b) <u>myocardial heat disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>acute myocardial failure</u>			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>S. Robert Wells MD</u>		DEPUTY MEDICAL EXAM. ADDRESS <u>157 N. Potomac Hagerstown, Md</u> DATE SIGNED <u>April 9 '51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/11/51</u> NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery</u> LOCATION (City, town, or county) (State) <u>near Clearspring Md</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Apr. 10, 1951</u>		24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 12 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Carmel - Rural</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Mt. Carmel - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>Keedysville Md. R. 1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>George</u> (Middle) <u>Josiah</u> (Last) <u>Robner</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Own Farm</u>	8. DATE OF BIRTH <u>May-8-1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	9. AGE last birthday <u>71-11-7</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Lorenza Quincy Robner</u>		11. BIRTHPLACE (State or foreign country) <u>Near Robesville Wash. Co. Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No. <u>None.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shipley</u>	
17. INFORMANT AND ADDRESS <u>Earl S. Robner Keedysville Md. R. 1</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Acute Myocardia

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Prostatic Hypertrophy1 month(c) Arteriosclerosis1 month

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Infectious1 month

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 15, 1951, to April 15, 1951, that I last saw the deceased alive on March 15, 1951, and that death occurred at 3:30 P.M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100105

RECEIVED
APR 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>28 E. Washington</u>		STREET ADDRESS (If rural, give location) <u>28 E. Washington St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Leah</u>	(First) <u>Virginia</u>	(Last) <u>Schindel</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>2</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 18, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>68</u> yrs. If under 1 year Months Days If under 24 hrs. Min.
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Martin L. Schindel</u>		14. MOTHER'S MAIDEN NAME <u>Ida Artz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT AND ADDRESS <u>Mr. H.A. Schindel</u>		<u>Hag. Md.</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Liver insufficiency</u>			<u>10 days</u>
(b) Antecedent cause(s) <u>Carcinoma, metastatic, liver</u>			<u>2 mo plus</u>
(c) <u>Carcinoma, primary rt breast</u>			<u>indefinite</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-2-51</u> , 19....., to <u>4-2-51</u> , 19....., that I last saw the deceased alive on <u>4-2-51</u> , 19....., and that death occurred at <u>7:35 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Robert F. Keadle</u> M. D.		ADDRESS <u>132 W. Washington St. Hagerstown, Md.</u>	
DATE SIGNED <u>4-4-51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Apr. 5, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>Apr. 5, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert F. Keadle</u>	24. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u> ADDRESS <u>Hag. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>235 S. Prospect Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>Courtney</u>	(Last) <u>Seaman</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 17, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car foreman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>R. R.</u>	8. DATE OF BIRTH <u>Nov. 1, 1885</u>	9. AGE last birthday <u>65</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>James Seaman</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
16. SOCIAL SECURITY No. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Nanie E. Lakin</u>	
17. INFORMANT AND ADDRESS <u>John Seaman Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Nephrosis</u>		<u>1 yr</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Myocardial Infarction</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>April</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>April 17</u> , 19 <u>51</u> , and that death occurred at <u>7 P</u> m., from the causes and on the date stated above.		
SIGNATURE <u>Robert W. Campbell MD</u>		DATE SIGNED <u>4/18/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>April 20 1951</u>	<u>Rest Haven Cemetery</u>
LOCATION (City, town, or county) (State)	<u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 18 1951</u>	REGISTRAR'S SIGNATURE <u>Frank H. Hovens</u>	24. FUNERAL DIRECTOR ADDRESS <u>Fred W. Kraiss Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

523506

RECEIVED
APR 20 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>834 Hamilton Blvd.</u>		STREET ADDRESS (If rural, give location) <u>834 Hamilton Blvd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ellen</u>	(Middle) <u>Elizabeth</u>	(Last) <u>Smith</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>30</u>	(Year) <u>1951</u>
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 25, 1874</u>
9. AGE last birthday <u>77</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home duties</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. Henry Smith</u>		14. MOTHER'S MAIDEN NAME <u>Anna Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. A. Ray Ruth Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ? Acute coronary occlusion(was found dead but evidently sudden)INTERVAL BETWEEN ONSET AND DEATH Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive Cardiovascular Disease10 years.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/8, 1941, to 4-30, 1951, that I last saw the deceasedalive on 4-6, 1951, and that death occurred at 11:20 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial May 2, 1951 Rose Hill Cemetery Hagerstown, Maryland

May 2, 1951 Chas. H. Bowers Fred W. Kraiss Hagerstown, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1

RECEIVED
MAY 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leitersburg</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Leitersburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington County Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Max</u>	<u>Rohrer</u>	<u>Snodderly</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>April</u>	<u>23</u>	<u>1951</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>male</u>	<u>white</u>	<u>Married</u>	<u>Jan. 28, 1886</u>
9. AGE last birthday	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
<u>65</u>	<u>7</u>	<u>23</u>	<u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
<u>machinist</u>	<u>tool company</u>	<u>Maryland</u>	<u>U.S.</u>
13. FATHER'S NAME <u>Daniel Snodderly</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Rohrer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>173-03-0528</u>	
17. INFORMANT AND ADDRESS <u>Nellie G. Snodderly</u>		<u>Leitersburg, Md.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>		<u>8 days</u>
Antecedent cause(s) (b) <u>Arteriosclerosis</u>		<u>Years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)
<u>SUICIDE</u>	<u>INJURY</u>	(COUNTY)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?
<u>April 22, 1951</u>	<u>While at Work</u>	<u>At work</u>

22. I hereby certify that I attended the deceased from April 22, 1951 to April 23, 1951, that I last saw the deceased alive on April 23, 1951, and that death occurred at 5:30 A.M. from the causes and on the date stated above.

SIGNATURE Henry Wiseman (Degree or title) MD. ADDRESS Hagerstown DATE SIGNED 4/24/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 25, 1951</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Apr. 24, 1951</u>	<u>Chas. H. Hower</u>	<u>Fred W. Kraiss</u>	<u>Hagerstown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

04201

544350

RECEIVED
100 26 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

04202

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 302

1. PLACE OF DEATH - COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Md. COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1628 Sherman Ave.		STREET ADDRESS (If rural, give location) 1628 Sherman Ave.,	
3. NAME OF DECEASED (Type or Print) (First) Carroll (Middle) Herbert (Last) Souders		4. DATE OF DEATH (Month) April (Day) 25 (Year) 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH July 14, 1909 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Airplane	9. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herbert Souders		14. MOTHER'S MAIDEN NAME Effie J. Moser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-2787	
17. INFORMANT Herbert Souders			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Acute carbon monoxide poisoning (suicide)

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) Home INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Apr. 25 51 1 A

INJURY OCCURRED While at work Not while at work

HOW DID INJURY OCCUR?

Inhaled exhaust fumes in closed garage

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 30, 1951

G. H. Bowers

Scott F. Minnich & Son

Hag. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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035 377

RECEIVED
MAY 2 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Norment

2411 N. Charles Street, Baltimore

04203

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>412 McDowell Ave.</u>		STREET ADDRESS <u>412 McDowell Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>GENEVIEVE</u> (First) <u>DAVIS</u> (Middle) <u>STOTLER</u> (Last)		4. DATE OF DEATH (Month) <u>April.</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 17, 1906</u>
9. AGE last birthday <u>44</u> yrs.	10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Doubs Md.</u>
13. FATHER'S NAME <u>Samael H. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Laura Carey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Isaac Stotler</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Acute dilatation of heart.</u>		<u>15 minutes</u>
Antecedent cause(s) (b) <u>Influenza.</u>		<u>1 month</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Broncho spasm - post influenza asthma</u>		<u>19 days</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		

19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 14, 1951, to April 14, 1951, that I last saw the deceased alive on April 14, 1951, and that death occurred at 4:5 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/17/51</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>Apr. 16, 1951</u>	REGISTRAR'S SIGNATURE <u>Dr. H. J. Jowers</u>	24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>	ADDRESS <u>Hagerstown Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

APR 18 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 376 S. Cleveland Ave.		STREET ADDRESS (If rural, give location) 376 S. Cleveland Ave.	
3. NAME OF DECEASED (Type or Print)	(First) Roy	(Middle) Ira	(Last) Stouffer
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH April 7, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	9. AGE last birthday 59 yrs.
13. FATHER'S NAME George M. Stouffer		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. 219-20-1896	
17. INFORMANT AND ADDRESS Anna M. Stouffer		Hagerstown, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Coronary Occlusion
(b) Chronic Endo-Carditi-
arterio-sclerosis

INTERVAL BETWEEN ONSET AND DEATH

3-4 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work Not While At work	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4/5, 1951, to 4/9, 1951, that I last saw the deceased alive on 4/9, 1951, and that death occurred at 5:30 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF April 12, 1951	NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Maryland
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Fred W. Kraiss		
			ADDRESS Hagerstown, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

573246

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APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04205

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co Hospital</u>		STREET ADDRESS (If rural, give location) <u>349 Ridge Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna Mary Strasbaugh</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>1</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 16 - 1892</u>
9. AGE last birthday <u>58</u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Adams Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Trost</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Witters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Frank S. Strasbaugh Ridge Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X Immediate cause (a) Uremia

Antecedent cause(s) (b) Nephrosclerosis

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Hypertensive C.V.D. disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Cholelithiasis</u>	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u> </u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1948, to Present, 19 , that I last saw the deceased alive on April 1, 1957, and that death occurred at 12:27 P.m., from the causes and on the date stated above.

SIGNATURE Robert F. Keable M.D. ADDRESS 132 W. WASHINGTON ST. DATE SIGNED 2/4/58

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 4, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Apr. 3, 1957</u>	REGISTRAR'S SIGNATURE <u>Frank S. Strasbaugh</u>	24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>	ADDRESS <u>Hagerstown Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penn</u> COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>	
TOWN <u>Washington County Hospital</u>		TOWN <u>Greencastle</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>35 W. Madison ST</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>EYER</u> <u>M.</u> <u>STRICKLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>26</u> <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan. 14, 1882</u>
9. AGE last birthday <u>69</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank P. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Altha D. Spickler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT, AND ADDRESS <u>A. E. Minnich Greencastle Pa</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral Haemorrhage about 48 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Obesity & arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Apr. 24, 1951, to Apr. 26, 1951, that I last saw the deceased alive on Apr. 25, 1951, and that death occurred at 6:58 A. m., from the causes and on the date stated above.

SIGNATURE <u>G. B. Gilliland</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Greencastle, Pa.</u>	DATE SIGNED <u>Apr 26 1951</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 29/51</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	LOCATION (City, town, or county) (State) <u>Greencastle Pa</u>
DATE REC'D BY LOCAL REG. <u>Apr. 26 1951</u>	REGISTRAR'S SIGNATURE <u>Frank P. Miller</u>	24. FUNERAL DIRECTOR <u>A. E. Minnich</u>	ADDRESS <u>Greencastle Pa</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

720826

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APR 30 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

04207

Reg. Dist. No. *300*

1. PLACE OF DEATH- COUNTY Washington CITY (If outside corporate limits, write RURAL and give nearest town) Sharpsburg TOWN 8 months HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md COUNTY Wash. CITY (If outside corporate limits, write RURAL and give nearest town) Sharpsburg TOWN 8 months STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Walter Leon (First) Robe (Middle) Stull (Last)	4. DATE OF DEATH April 1 (Month) 1951 (Year)	5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single 8. DATE OF BIRTH Sept. 26, 1950 9. AGE last birthday 6 yrs. 8 months 8 days 8 hours 8 min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hagerstown, Md 12. CITIZEN OF WHAT COUNTRY U. S	
13. FATHER'S NAME Walter Leo Stull		14. MOTHER'S MAIDEN NAME Sara Rowe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY No. None 17. INFORMANT Miss Sara Rowe	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Acute Malnutrition Antecedent cause(s) (b) Starvation due to deprivation of food. Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) Prematurity 926.0 1950		(5-23-51 - ans)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 1951 to July 1951 , that I last saw the deceased live on July 1951 , and that death occurred at 3:04 PM , from the causes and on the date stated above.			
SIGNATURE D. S. Deady M.D., Hagerstown, Md		DATE SIGNED 7/1/51	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	April 2, 1951	Mt. Briar	Keedysville, Md. R. F D
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
4-2-51	4-2-51	R. I. Earnshaw -Keedysville, Md	

209260181974

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

04208

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>West of Clear Spring Route 40</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>High Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Katherine Brooke Taylor</u>		4. DATE OF DEATH <u>April 11, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1-8-74</u>
9. AGE last birthday <u>77</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Brooke</u>	
14. MOTHER'S MAIDEN NAME <u>Rachel Gregory</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If year, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT <u>Mrs. Mabel Richards (sister)</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Strang Thrombosis</u>		<u>Anterior Sclerosis</u>	<u>4 Days</u>
Antecedent cause(s) (b) <u>420.1 94a</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>April 8, 51</u> to <u>April 11, 51</u> , that I last saw the deceased alive on <u>April 11, 51</u> , and that death occurred at <u>1230 A.M.</u> , from the causes and on the date stated above.		23. BURIAL, CREMATION REMOVAL (Specify) <u>150722P</u> DATE <u>4-13-51</u> NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cem.</u> LOCATION (City, town, or county) <u>Hancock, Md.</u> (State) <u>Md.</u>	
SIGNATURE <u>[Signature]</u> (Degree or title) ADDRESS <u>[Address]</u> DATE SIGNED <u>4/13/51</u>		24. FUNERAL DIRECTOR <u>Charles R. Bast, Hancock, Md.</u> ADDRESS <u>[Address]</u>	
DATE REC'D BY LOCAL REG. <u>4/12/51</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 16 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

04209

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Hancock</u> LENGTH OF STAY (in this place) <u>6 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. #1</u>		STREET ADDRESS (If rural, give location) <u>R.F.D. #1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Helen</u>	(Middle) <u>May</u>	(Last) <u>Trail</u>
4. DATE OF DEATH	(Month) <u>Apr.</u>	(Day) <u>3</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-23-75</u>
9. AGE last birthday <u>75</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>Josephus Norris</u>	14. MOTHER'S MAIDEN NAME <u>Mary + Frances Creek</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	16. SOCIAL SECURITY No. <u>—</u>	17. INFORMANT <u>Wilbur Trail - son</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Unknown/Probably Cardiac</u>		
Antecedent cause(s) (b) <u>Unknown</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>950</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY
(CITY OR TOWN)	(COUNTY)
(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not White At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE H. E. Tabler M.D. ADDRESS Hancock Md DATE SIGNED 4/24/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Burial</u>	<u>4-6-51</u>	<u>Piney Plains Meth.</u>	<u>Allegheny Co. Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/6/51</u>	<u>J. A. Steller</u>	<u>Charles R. Bast</u>	<u>Hancock, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

04210

Item 8 on:

2411 N. Charles Street, Baltimore

FILM No. G 132 MAY 14 1951

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>622 George St.</u>		STREET ADDRESS (If rural, give location) <u>622 George Street</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Mary Catherine</u> (Middle) <u>Truett</u> (Last) <u>Sept. 7</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>26</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Apr. 26, 1951</u> 9. AGE last birthday <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa.</u>
13. FATHER'S NAME <u>David W. Eley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Savilla G. Embly, Hag. Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Coronary Occlusion</u>		<u>Suddenly</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Arteriosclerotic Heart Disease</u>		<u>Years</u>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Dec 19, 1947, to April 26, 1951, that I last saw the deceased alive on April 25, 1951, and that death occurred at 3:40 p.m., from the causes and on the date stated above.

SIGNATURE [Signature] (Degree or title) MD ADDRESS Hagerstown Md DATE SIGNED 4/27/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Apr. 29, 1951</u>	<u>Rest Haven Cemetery</u>	<u>Hagerstown, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>Apr 29 1951</u>	<u>[Signature]</u>	<u>Scott F. Minnich & Son Hag. Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L 0 L

dog 6 0881
ndy 78 61
91 25

1881
8L
1566

RECEIVED
MAY 1 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

04211

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wash.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Hancock</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hancock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>John Wesley Unger</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 11, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12-6-08</u>
9. AGE last birthday <u>50</u> yrs.		10. If under 1 year: Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (blind)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sherrard Unger</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Crouse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Nellie Ray Unger (wife)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic myocarditis</u>			
581.0 Antecedent cause(s) (b) <u>Cirrhosis liver</u>			<u>4 yrs</u>
124.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Pulmonary edema</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 1, 1957 to April 11, 1957, that I last saw the deceased alive on April 10, 1957, and that death occurred at 12:05 A.M. from the causes and on the date stated above.

SIGNATURE W. H. Shaffer M.D. (Degree or title) ADDRESS Hancock Md DATE SIGNED 4/12/57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>4-13-57</u>	NAME OF CEMETERY OR CREMATORY <u>Greenway Cemetery</u>	LOCATION (City, town, or county) (State) <u>Berkeley Springs W. Va.</u>
DATE REC'D BY LOCAL REG. <u>4-11-57</u>		REGISTRAR'S SIGNATURE <u>W. H. Shaffer</u>		24. FUNERAL DIRECTOR <u>Charles R. Bast, Hancock, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 16 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04212

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>433 West Washington Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Dianna</u>	(Middle) <u>Marie</u>	(Last) <u>Ward</u>
4. DATE OF DEATH	(Month) <u>Apr.</u>	(Day) <u>23</u>	(Year) <u>51</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4-23-1951</u>
9. AGE last birthday		If under 1 year	If under 24 hrs.
yrs.		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Francis Thomas Ward</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Theresa Perks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. (If yes, give war or dates of service)	
17. INFORMANT AND ADDRESS <u>Francis T. Ward</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Respiratory Failure</u>			<u>4 hrs</u>
Antecedent cause(s) (b) <u>Pneumonia</u> (7 mos. incub)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY			
22. I hereby certify that I attended the deceased from <u>4-23-51</u> , 19 <u>51</u> , to <u>4-24-51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>4-24</u> , 19 <u>51</u> , and that death occurred at <u>Hagerstown, Md.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Charles W. Ward</u>		ADDRESS <u>Hagerstown, Md.</u>	
DATE SIGNED <u>Apr. 25, 1951</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-25-1951</u>	<u>Rose Hill Cemetery</u>	<u>Hagerstown, Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Apr. 25, 1951</u>	<u>Charles W. Ward</u>	<u>C. M. Suter & Sons</u>	<u>Hagerstown, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

204231299343

Dr. Earl Young

RECEIVED

APR 27 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beaver Creek - Rural</u> TOWN <u>Beaver Creek</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hagerstown md. R.I.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beaver Creek</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location) <u>Hagerstown md. R.I.</u>	
3. NAME OF DECEASED (Type or Print) <u>Clara</u> (First) <u>Frank</u> (Middle) <u>Wagley</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>10</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 5 - 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE last birthday <u>82-6-5</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Beaver Creek Wash. Co. md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel F. Frank</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>now</u>	
17. INFORMANT AND ADDRESS <u>R.C.D. Wagley Hagerstown md. R.I.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

7 yrs.

420.0 Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

(b) Thrombo Angiitis Obliterans10 wks.

93d

(c) Arteriosclerosis - generalized7 wks.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 27, 1951, to Apr. 10, 1951, that I last saw the deceasedalive on Apr. 10, 1951, and that death occurred at 10:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE TIME OF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr. 12, 1951John H. EastWm. J. East & Sons Beavercreek mdApr. 11-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Lloyd A. Hoffman
14 N. Pine St.
Hagerstown md

04213

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

04214

1. PLACE OF DEATH- COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hagerstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>		STREET ADDRESS (If rural, give location) <u>107 N. Foundry Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>George</u>	(Middle) <u>W.</u>	(Last) <u>Wilkinson</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>7</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 18, 1868</u>
9. AGE last birthday <u>82</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture fact.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lawson Wilkinson</u>		14. MOTHER'S MAIDEN NAME <u>Julia Stead</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Florence L. Wilkinson Hagerstown, Md.</u>			

18. MEDICAL CERTIFICATION		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
(a) Immediate cause <u>Arterio sclerotic heart disease</u>		
(b) Antecedent cause(s) <u>Generalized arterio sclerosis</u>		
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u> </u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>
22. I hereby certify that I attended the deceased from <u>April 7, 1951</u> , to <u>April 7, 1951</u> , that I last saw the deceased alive on <u>April 7, 1951</u> , and that death occurred at <u>3:55</u> p.m., from the causes and on the date stated above.		
SIGNATURE <u>Dr. J. H. Powers</u> (Degree or title)		DATE SIGNED <u>April 10, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 10, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>
LOCATION (City, town, or county) <u>Hagerstown, Maryland</u>		(State) <u>Md.</u>
DATE REC'D BY LOCAL REGISTRY <u>April 10, 1951</u>	REGISTRAR'S SIGNATURE <u>J. H. Powers</u>	24. FUNERAL DIRECTOR <u>Fred W. Kraiss</u>
ADDRESS <u>Hagerstown, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

670309

RECEIVED

APR 12 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04295

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH- COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wash. Co. Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>4 hrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> TOWN <u>Hagerstown</u> STREET ADDRESS <u>130 Ray St.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Charles</u> (Middle) <u>Edward</u> (Last) <u>Cuselle</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1951</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 29, 1906</u>	9. AGE last birthday <u>44-4-1</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Cuselle</u>	
14. MOTHER'S MAIDEN NAME <u>Ada Gross</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs. Ada B. Knudle 130 Ray St. Hagerstown Md.</u>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

1 Day

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED HOW DID INJURY OCCUR?
OF While at Not While
INJURY Work ☐ At work ☐

22. I hereby certify that I attended the deceased from 4/30/51, 1951, to 4/30/51, 1951, that I last saw the deceased

alive on 4/30/51, 1951, and that death occurred at 10:00 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Sept. 4, 1951Wm. J. BaskinsWm. J. BaskinsBaltimore Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
SEP 6 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Dr. Hochlander 04215

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u> COUNTY <u>MONTGOMERY</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u> TOWN <u>Philadelphia</u> STREET ADDRESS (If rural, give location) <u>310 Bala Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>BELLE</u> (First) <u>LOUISE</u> (Middle) <u>YOUNG</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>17</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11/27/1868</u>
9. AGE last birthday <u>82</u> yrs.		10. CITIZEN OF WHAT COUNTRY <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fredonia, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>August Holmberg</u>		14. MOTHER'S MAIDEN NAME <u>Susan Hudnall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Paul E. Hovgard</u>		18. MEDICAL CERTIFICATION <u>629 Oak Hill Ave. Hagerstown, Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of ovary

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 2, 1951, to April 12, 1951, that I last saw the deceased alive on Mar 12, 1951, and that death occurred at 8:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Apr 18, 1951 Phas H. Boovers Andrew K. Coffman Hagerstown Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 20 1951
BUREAU V. S.